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# **The concept of comorbidity in somatoform disorder—a *DSM-V* alternative for the *DSM-IV* classification of Somatoform disorder**<sup>☆</sup>

Dear Editor:

Somatoform disorders, first introduced as such in *DSM-III*, are a controversial category, and the concept of comorbidity seems to play an essential role in this controversy [1–3]. Presentation of depressive disorder or other psychological distress by medical symptoms is common in many cultures [4] as established in research in several countries and health care settings, and it has been established that depressed patients indeed do not feel well physically. This somatic presentation negatively influences recognition of the depressive disorder or other mental disorder by the general practitioner, which results in undertreatment of a majority of patients. Although comorbidity between somatoform disorders, mood disorders, and anxiety disorders is high [2,5,6], it is not handled as an uniform criterion in the heterogeneous set of somatoform disorders assembled as such in the *DSM-IV*. In some somatoform disorders, including pain disorder, hypochondriasis, body dysmorphic disorder, and the undifferentiated type, *DSM-IV* specifies the presence of a comorbid mental disorder as an exclusion criterion. In contrast, it does not do so for conversion disorder, somatization disorder, or somatoform disorder not otherwise specified. Furthermore, the exclusion criterion that is specified—that the symptoms are not better accounted for by the comorbidity than by the somatoform disorder itself—is difficult to apply in clinical practice. The question has been raised if not comorbidity, but co-syndromality is the case for depressive, anxiety, and somatoform disorder. Cosyndromality is the phenomenon that a symptom spectrum has physical as well as psychological symptoms that are classified in different syndromes that are nevertheless of similar kin [7]. An increasing literature on the Diagnostic Criteria for Psychosomatic Research (DCPR) has attempted to better capture the essential diagnostic issues in such patients, which can be useful in cases where anxiety and depression do not account for the symptomatology of functional disorders [8]. However, the need to redefine the concept of somatoform disorders in *DSM-V* is broadly felt, and in this letter, we would like to suggest a contribution to the discussion by focusing on reformulation of the concept of somatoform disorder in *DSM-V*.

Several authors have suggested the whole category of Somatoform disorders in *DSM-V* be scrapped. As an alternative, these authors suggest either physical illness with psychological factors be recorded on Axis I or functional physical symptoms on Axis III [9]. Otherwise, “physical symptom disorder” has been suggested by the Conceptual Issues in Somatoform and Similar Disorders Work Group to replace somatization disorder, undifferentiated

tiated somatoform disorder, and pain disorder, as a diagnostic category that should reside in Axis III [10,11]. Fava et al. [12], in line with the work of the DCPR, suggested the term *psychological factors affecting either identified or feared medical conditions not otherwise specified*, and in an editorial in this Journal, an overview is given of the concept of Somatic Symptom Disorders as envisioned by the *DSM-V* workgroup [13]. Although these suggestions to remove the category of somatoform disorders are very worthwhile, they imply to replace them by another distinct category. We would suggest taking this one step further, as follows.

Somatoform disorder is a negative diagnosis: it implies the lack of evidence for somatic illness. It would be of great clinical benefit if not a negative diagnosis but a positive diagnosis could be made. Therefore, no distinct category for the symptoms so far categorized as somatoform disorder should exist as a separate category, and the clinician should be challenged to classify the symptoms otherwise, positively, with clues for treatment. Surely, eliminating somatoform disorder from the classification system does not eliminate the somatic presentation of a cosyndromal mood disorder or anxiety disorder by patients, and this behavior should be mentioned in a classification system if it is so overbearing that it has a negative influence on diagnosis and treatment of the cosyndromal disorder. Such behavioral and learned patterns in the doctor-patient interaction, in which depressed patients tend to present to doctors with physical symptoms, are very important to guide us in the diagnostic procedures and treatments that we follow for these patients. However, help-seeking behavior is not necessarily a disorder, and the concept of a depressive or anxiety disorder with somatic presentation might protect primary care practitioners and psychiatrists from non therapeutic behavior. Therefore, we suggest that the essence of what is now commonly classified as somatoform disorder should be the help seeking behavior that focuses on the “wrong” medical specialist or treatment setting. *DSM-V* should facilitate diagnosis and classification of cosyndromal depressive or other disorders that come into place as candidates for specific treatment as much as possible. The help-seeking behavior, if it indeed disturbs treatment as needed, should be introduced as a sub classification of the diagnosed depressive or anxiety disorder, in the classification of mood disorders and anxiety disorders in *DSM-V*. Somatoform disorders as category can then be abolished and should not be replaced by another distinct category. The differential aspects between *DSM-IV* and the proposed classification in *DSM-V* is shown in Table 1.

We suggest the concept of *depressive disorders* and *anxiety disorders* be expanded in *DSM-V* with the following sub classifications that have clear implications for treatment: (1) with pain, (2) with somatic presentation, or (3) with hypochondriacal worries. In the minority of cases in which criteria for another classification such as depressive or anxiety disorder cannot be met, in which medical illness or medical symptoms exists, but the illness behavior is a clear disturbing factor in medical treatment, we suggest

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Table 1  
Differential Aspects Between *DSM-IV* and the new proposed Classification in *DSM-V*

<i>DSM-IV</i>	New proposed classification
Somatization disorder	Deleted. In case of >4 symptoms reported: V code in Axis I: multisymptomatic medically unexplained symptoms with noncompliance to treatment. In Axis III mentioning of the reported medical symptoms.
Conversion disorder	Deleted. Removed to Dissociative disorder section of <i>DSM-V</i> as a Dissociative disorder with conversion.
Body dysmorphic disorder	Deleted. Removed to anxiety disorder section of <i>DSM-V</i> as an Obsessive Compulsive Disorder with Body Dysmorphic preoccupations.
Pain disorder	Deleted. Removed to depressive disorder or anxiety disorder section of <i>DSM-V</i> as subcategory with pain.
Hypochondriasis	Deleted. Removed to Depressive disorder or anxiety disorder section of <i>DSM-V</i> as subcategory with hypochondriasis.
Somatoform disorder Not Otherwise Specified	Deleted. Removed to Depressive disorder or Anxiety disorder section of <i>DSM-V</i> as subcategory with somatic presentation.
Undifferentiated somatoform disorder	Deleted. Removed to Depressive disorder or Anxiety disorder section of <i>DSM-V</i> as subcategory with somatic presentation.
Illness behavior as a clear disturbing factor in medical treatment, without Axis I pathology. This code should be used in case of <4 presented symptoms.	V code in Axis I: medical symptoms or medical illness with non compliance to treatment. In Axis III, mentioning of the reported medical symptoms or medical illness.

classification as the V-code “medical symptoms or medical illness with non compliance to treatment” in Axis I, with mentioning of the symptoms in Axis III. In the case of somatization disorder, we suggest classification as the V-code “multisymptomatic medically unexplained symptoms with non-compliance to treatment” in Axis I, with mentioning of the symptoms in Axis III. As can be seen, somatization disorder is thus removed, conversion disorder is moved to the dissociative disorders section, and body dysmorphic disorder, to the Anxiety Disorders section; in this letter, we focus on the comorbidity-related issues.

In summary, the decision to abolish the category of somatoform disorders as such and to compel clinicians to classify somatic symptom presentation as a behavioral feature of cosyndromal depressive or anxiety disorder or as noncompliance to treatment on Axis I is supported by a vast body of research and would offer a positive criterion for classification as well as clues for treatment that are badly needed in the clinical management of these patients.

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## References

- [1] Escobar JI, Gara MA. *DSM-IV* somatoform disorders: do we need a new classification? *Gen Hosp Psychiatry* 1999;21:154–6.
- [2] Greeven A, Van Balkom ALLM, Van Rood YR, Van Oppen P, Spinhoven P. The boundary between hypochondriasis and obsessive-compulsive disorder: a cross-sectional study from the Netherlands. *J Clin Psychiatry* 2006;67:1682–9.
- [3] Noyes R, Kathol R, Fisher MM, Phillips BM, Suelzer MT, Woodman CL. Psychiatric Comorbidity Among Patients with Hypochondriasis. *Gen Hosp Psychiatry* 1994;16:78–87.
- [4] Escobar JI, Burnam MA, Karno M, Forsythe A, Golding JM. Somatization in the community. *Arch Gen Psychiatry* 1987;44:713–8.
- [5] de Waal MW, Arnold IA, Eekhof JA, Van Hemert AM. Somatoform disorders in general practice: prevalence, functional impairment and comorbidity with anxiety and depressive disorders. *Br J Psychiatry* 2004;184:470–6.

- [6] Van der Feltz-Cornelis CM, van Oppen P, Adèr H, van Dyck R. Randomised controlled trial of a collaborative care model with psychiatric consultation for persistent medically unexplained symptoms in general practice. *Psychother Psychosom* 2006;75:282–9.
- [7] Van der Feltz-Cornelis CM. Unexplained or undiagnosed? To a *DSM-V* for somatoform disorder. Comment on van Dieren & Vingerhoets (Onverklaard of ondoordacht? Naar een *DSM-V* van somatoforme stoornissen). *Tijdschr Psychiatr* 2007;1997:839–43.
- [8] Fava GA, Freyberger HJ, Bech P, Christodoulou G, Sensky T, Theorell T, et al. Diagnostic criteria for use in psychosomatic research. *Psychother Psychosom* 1995;63:1–8.
- [9] Mayou R, Kirmayer LJ, Simon G, Kroenke K, Sharpe M. Somatoform disorders: time for a new approach in *DSM-V*. *Am J Psychiatry* 2005;162:847–55.
- [10] Kroenke K. Physical symptom disorder: a simpler diagnostic category for somatization-spectrum conditions. *J Psychosom Res* 2006;60:335–9.
- [11] Kroenke K, Sharpe M, Sykes R. Revising the classification of somatoform disorders: key questions and preliminary recommendations. *Psychosomatics* 2007;48:277–85.
- [12] Fava GA, Wise TN. Issues for *DSM-V*: psychological factors affecting either identified or feared medical conditions: a solution for somatoform disorders. *Am J Psychiatry* 2007;164:1002–3.
- [13] Dimsdale J, Creed F. The proposed diagnosis of somatic disorders in *DSM-V* to replace somatoform disorders in *DSM-IV*—a preliminary report. *J Psychosom Res* 2009;66:473–6.

### **The proposed diagnosis of somatic symptom disorders in *DSM-V* to replace somatoform disorders in *DSM-IV*—A preliminary report**

#### **Author's response to letters from Schröder and van der Feltz-Cornelis**

We are pleased that the authors of these letters appreciate our efforts to be open regarding the proposed changes to the diagnostic criteria of the Somatoform Disorders chapter of *DSM-IV* [1,2]. It is gratifying also that they concur with our impression that the *DSM-IV* chapter needs extensive modification and they have made valuable contributions to the debate regarding these criteria. We agree with the suggestion in both letters that we should avoid the unhelpful terms 'somatoform' and 'medically unexplained.'

Schröder and Fink [1] comment on the three criteria that have been proposed for the comprehensive diagnosis, provisionally entitled "Complex Somatic Symptom Disorder." With regard to the first criterion point, we note their concern that the draft description, as provided in our article, seemed to give undue emphasis to matters such as patients' difficulty coping with, and tolerating, physical discomfort. As a result of this and other feedback, we are likely to modify this section. What we are striving for is a description of the disorder that is precise and unambiguous.

We do respect the knowledge and experience of clinicians treating patients with "severe and chronic functional symptoms and somatization disorder," but our proposed definition must define a much broader group of patients than this, including those seen frequently in

primary care. Population surveys are therefore relevant, but we read the evidence differently from Schröder and Fink [1]. We do not interpret existing evidence as indicating that medically unexplained symptom clusters into gastrointestinal, cardiopulmonary, and musculoskeletal clusters "with specific neurobiological disturbances underlying these clusters." Schröder and Fink [1] quote their own study in this respect together with several others in Table 1, but they omit three other important studies [3–5] all of which found evidence for a single factor underlying a large number of symptoms. Both the study of Deary [6] and a systematic review concluded that the data do not provide convincing support for a consistent picture of the clustering of somatic symptoms [7]. We believe therefore that it is premature to conclude that clusters of symptoms with specific underlying neurobiological disturbances can be used to build a diagnostic scheme. By proposing a single, inclusive diagnosis of complex somatic symptoms, we aim, in this section of *DSM-V*, to allow future research to test whether particular patterns of symptoms are indeed supported by epidemiological research and whether these are found to have biological substrates. We guard against making premature subdivisions which may limit the usefulness of future research.

The same approach would prevent us from accepting the evidence provided by Schröder and Fink [1] that health anxiety should be defined as a separate category from that primarily representing numerous bodily symptoms. We regard this as a premature conclusion as, once again, the evidence of overlap between numerous bodily symptoms and health anxiety is very considerable, up to 60% according to one study [7] and nearly 50% in Fink's own study [8].

With regard to our third criterion, increased pattern of health care use, Schröder and Fink [1] reject this as a basis for making a diagnosis. In their view, the "evidence is 'unequivocal' that the Health System as a whole and the doctor/patient consultation in particular assume an important role in the initiation and maintenance of so called medically unexplained symptoms." They think therefore that it is wrong to blame the patient for what they regard as shortcomings in the health care system and doctor's lack of communication skills. The workgroup accepts the evidence that there are difficulties in some doctor–patient encounters for the patients in this group and we have been exploring ways of operationalizing the unsatisfactory nature of the utilization.

In their letter, van der Feltz-Cornelis and van Balkom [2] support the suggestion, previously made by Mayou et al. [9], that the whole category of somatoform disorders be scrapped. They suggest (a) that the majority of patients previously diagnosed as "somatoform disorder" could be encompassed in the diagnoses of depressive or anxiety disorder and (b) that these latter diagnoses could be enhanced by subcategories indicating that the depression or anxiety is accompanied by pain, somatic presentations, or hypochondriacal worries.